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November 18, 2009

Senator John L. Valentine, Senate Chair, Business and Labor Interim Committee
Representative James A. Dunnigan, House Chair, Business and Labor Interim Committee

Subject:: Health System Reform Task Force Preliminary Report

Dear Chairs:

Although the work of the Health System Reform Task Force is not yet completed, we are providing a preliminary report for consideration at your November interim meeting. Accompanying this report is a draft bill recommended by the Task Force ("Health Reform - Administrative Simplification") and two other draft bills the Task Force will review at its November interim meeting ("Amendments to Health Insurance Coverage in State Contracts" and "Health Reform - Uniform Electronic Standards - Insurance Information").

The Task Force is authorized to work through December 30. Although we have no additional meetings scheduled, we may meet again to further consider issues outlined below and related draft legislation.

ORGANIZATION OF TASK FORCE Work During 2008, the Task Force relied heavily on the expertise and input of five working groups organized around functional areas within the health care system—consumers, employers, insurers, physicians, and hospitals. This year, the Task Force reorganized the workgroup structure to create three working groups and several technical advisory groups (TAGs) working under their direction. Each workgroup addressed a specific set of tasks and reported to the Task Force. The result of this work is summarized below and, in some cases, incorporated into the accompanying draft legislation. Detailed information about the issues studied by the Task Force and its working groups is available at http://www.le.utah.gov/asp/interim/Commit.asp?Year=2009&Com=TSKHSR (see especially http://www.le.utah.gov/interim/2009/pdf/00001033.PDF).

Focus During the 2007, 2008, and 2009 General Sessions, the Legislature enacted legislation designed to lay a foundation for significant future health care reform. The Task Force's work during the 2009 interim focused largely on ensuring that work on this foundation is proceeding as planned. Major topics considered by the Task Force and its subgroups are outlined below.

INSURANCE MARKET REFORM On August 19, the state opened the second of only two health insurance purchasing exchanges in the country. The Exchange is a virtual marketplace that emphasizes various elements of consumerism—availability of price and quality information about plans, availability of insurer performance information, availability of a large number of plan choices from which individual employees—rather than employers—may choose, and capacity to aggregate financial resources from multiple sources to make a purchase.

Interest in the Exchange has been strong. Enrollment was closed after only two weeks. Enrollment will be limited for a period but then opened to all small employer groups later next year and to large employer groups in 2012.

The Task Force has closely monitored the development of various aspects of the Exchange, including the availability and cost of plans, the availability of consumer information, and the development of a risk-adjusting mechanism by the Utah Defined Contribution Risk Adjuster Board. Our Oversight and Implementation Workgroup has considered various statutory amendments relating to the Exchange, including the following:

- allowing for continuous enrollment;
- clarifying price, value, and performance provisions;
- convening a group to study simplification of the uniform health insurance application; and
- allowing an insurer in the defined contribution market to offer a product with an actuarial value 15% less than the basic benefit package.

The Task Force is not recommending at this time that any of these amendments, or other changes to the insurance market, be adopted. This, however, may change between now and the 2010 General Session.

PAYMENT AND DELIVERY REFORM Pursuant to 2009 legislation, the State has contracted with *HealthInsight*, a recognized health care quality improvement organization, to work with medical providers, insurers, and others to develop pilot programs that test payment and delivery reform concepts. This includes medical home, bundled payment, and shared savings concepts. *HealthInsight* expects to enlist medical providers early next year and provide preliminary results sometime during the 2010 interim. The first two projects test payment reform using a chronic care delivery model (for patients with diabetes) and an acute care delivery model (for pregnant patients). The Task Force and our Transparency, Quality, and Infrastructure Workgroup have monitored the development of these projects. *We are not recommending legislation at this time to facilitate, expand, or accelerate these projects.*

ADOPTION OF HEALTH INFORMATION TECHNOLOGY Pursuant to 2008 legislation, the Utah Health Information Network (UHIN) has developed standards for electronic clinical health information exchange (cHIE) across providers belonging to different health care systems or no system at all. UHIN has begun to pilot data exchange in three locations—Moab, Box Elder County, and

Cache County. Of the 168 physicians in these areas, 161 have indicated they wish to participate in the pilots. Statewide implementation is expected to begin January 2010. It is expected that use of cHIE will lead to greater use of electronic medical records and, based on results elsewhere, lower prescribing rates and decreased use of emergency departments.

The Task Force is not recommending any legislative action at this time to facilitate or accelerate electronic clinical health information exchange.

ALL-PAYER DATABASE (APD) In response to 2007 legislation, the Department of Health has been developing the capacity to produce risk-adjusted payment data for entire episodes of medical care. APD data will differ from existing data which report what *providers charge*. APD data will instead report what *insurers pay* and will be rolled up across visits and providers to arrive at the cost of treating entire episodes of care (e.g., the cost of treating a coronary obstruction, which may involve multiple providers, procedures, and patient visits).

The all-payer database is expected to enable and accelerate transformational payment and delivery reform. The data will be used to identify insurance plan provisions and provider practice patterns that result in higher quality care and lower costs. Ultimately, the data may be used by consumers in the selection of insurance plans and health care providers.

The Task Force is not recommending any legislation at this time relating to the development and operation of the all-payer database.

INSURANCE IN STATE CONTRACTS In 2009 the Legislature passed legislation that would require employers contracting with certain government agencies to offer their employees health insurance. Our Oversight and Implementation Workgroup studied this legislation and suggested several changes. Those changes are recommended by the Task Force and are included in accompanying draft legislation, "Amendments to Health Insurance Coverage in State Contracts." They include:

- clarifying to whom qualified insurance must be offered;
- clarifying what may be offered;
- clarifying how an employer offering a defined contribution arrangement may comply;
- clarifying the application of a waiting period; and
- amending enforcement provisions.

ADMINISTRATIVE SIMPLIFICATION In 2009 the Legislature passed legislation designed to simplify various aspects of health insurance administration. The Task Force's Affordability and Access Workgroup reviewed this legislation and prepared amendments for consideration during the 2010 General Session. The Task Force recommends these amendments, included in two accompanying pieces of draft legislation, "Health Reform - Uniform Electronic Standards - Insurance Information" and "Health Reform - Administrative Simplification." They include:

- amending provisions related to uniform electronic standards for health insurance claims processing, electronic insurance eligibility information, and electronic information regarding the coordination of benefits;
- establishing a voluntary registry of software vendors who comply with electronic standards;
- providing uniform language for divorce decrees and child support orders related to the coordination of health insurance benefits when a dependent child of a marriage is covered by both parents' health insurance policies;
- establishing a coordination of benefits process for health insurance claims based primarily on national standards;
- providing uniform educational material for the public regarding the coordination of health insurance benefits;
- repealing the coordination of health insurance benefits process that was to take effect July 1, 2010; and
- making clarifying and technical amendments.

Public Employees Health Program The Task Force's Transparency, Quality, and Infrastructure Workgroup conducted an in-depth review of the extent to which the state's Public Employee's Health Program (PEHP) incorporates and might further incorporate various reform concepts to reduce cost, improve care, incentivize personal responsibility, and create individual and provider accountability. The concepts reviewed included bundled payments, premium differentials based on wellness program participation or outcomes, health savings accounts, and use of lower-cost care providers (health clinics, ambulatory surgery centers, medical tourism providers, and alternative medicine providers).

PEHP will continue to study the desirability of incorporating these concepts in its plans. The Task Force is not recommending any legislative action at this time relating to PEHP.

Promotion of Wellness The Task Force's Affordability and Access Workgroup reviewed approaches to improving individual and community wellness but made no recommendations. The Task Force received a report on the development of a community-wide initiative in Midvale to promote healthy behaviors. The Task Force is not recommending any legislative action at this time to address wellness promotion.

Tort Reform The Task Force's Transparency, Quality, and Infrastructure Workgroup reviewed how Utah medical liability laws compare with the laws of other states and how Utah's approach to medical liability might be modified. The Task Force is not recommending legislation at this time to address medical liability.

Access to Public Programs The Task Force's Affordability and Access Workgroup reviewed options for facilitating enrollment in the Children's Health Insurance Program, Medicaid, and the

Utah's Premium Partnership for Health Insurance (UPP). These options included methods for identifying individuals eligible for programs and eliminating barriers to enrollment. The Task Force is not recommending legislation at this time to address access to public programs.

For further information, please feel free to contact us or other members of the Task Force.

Sincerely,

Speaker David Clark
House Chair
Health System Reform Task Force

Senator Sheldon L. Killpack
Senate Chair
Health System Reform Task Force

Enclosures:
Health Reform - Administrative Simplification
Amendments to Health Insurance Coverage in State Contracts
Health Reform - Uniform Electronic Standards - Insurance Information

HEALTH REFORM - ADMINISTRATIVE SIMPLIFICATION

2010 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends provisions related to administrative simplification of the coordination of health insurance benefits as provided in divorce decrees, child support orders, and the Insurance Code.

Highlighted Provisions:

This bill:

- provides uniform language for divorce decrees and child support orders related to the coordination of health insurance benefits when a dependent child of the marriage is covered by both parents' health insurance policies;
- establishes a coordination of benefits process for health insurance claims based primarily on national standards;
- provides uniform educational material for the public regarding the coordination of health insurance benefits; and
- repeals the coordination of health insurance benefits process that was to take effect July 1, 2010.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

30-3-5, as last amended by Laws of Utah 2005, Chapter 129

31A-22-619, as last amended by Laws of Utah 2009, Chapter 11

63I-2-231, as last amended by Laws of Utah 2009, Chapter 11

62A-11-326, as last amended by Laws of Utah 2009, Chapter 142

78B-12-212, as last amended by Laws of Utah 2009, Chapter 142

ENACTS:

30-3-5.5, Utah Code Annotated 1953

REPEALS:

31A-22-619.5 (Effective 07/01/10), as enacted by Laws of Utah 2009, Chapter 11

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **30-3-5** is amended to read:

30-3-5. Disposition of property -- Maintenance and health care of parties and children -- Division of debts -- Court to have continuing jurisdiction -- Custody and parent-time -- Determination of alimony -- Nonmeritorious petition for modification.

(1) When a decree of divorce is rendered, the court may include in it equitable orders relating to the children, property, debts or obligations, and parties. The court shall include the following in every decree of divorce:

(a) an order assigning responsibility for the payment of reasonable and necessary medical and dental expenses of the dependent children including responsibility for health insurance out-of-pocket expenses such as co-payments, co-insurance, and deductibles;

(b) (i) if coverage is or becomes available at a reasonable cost, an order requiring the purchase and maintenance of appropriate health, hospital, and dental care insurance for the dependent children; and

(ii) a designation of which health, hospital or dental insurance plan is primary and which health, hospital, or dental insurance plan is secondary in accordance with the provisions of Section 30-3-5.5 which will take effect if at any time a dependent child is covered by both parents' health, hospital or dental insurance plans.

(c) pursuant to Section 15-4-6.5:

(i) an order specifying which party is responsible for the payment of joint debts, obligations, or liabilities of the parties contracted or incurred during marriage;

(ii) an order requiring the parties to notify respective creditors or obligees, regarding the court's division of debts, obligations, or liabilities and regarding the parties' separate, current addresses; and

(iii) provisions for the enforcement of these orders; and

(d) provisions for income withholding in accordance with Title 62A, Chapter 11, Recovery Services.

(2) The court may include, in an order determining child support, an order assigning financial responsibility for all or a portion of child care expenses incurred on behalf of the dependent children, necessitated by the employment or training of the custodial parent. If the court determines that the circumstances are appropriate and that the dependent children would be adequately cared for, it may include an order allowing the noncustodial parent to provide child care for the dependent children, necessitated by the employment or training of the custodial parent.

(3) The court has continuing jurisdiction to make subsequent changes or new orders for the custody of the children and their support, maintenance, health, and dental care, and for distribution of the property and obligations for debts as is reasonable and necessary.

(4) Child support, custody, visitation, and other matters related to children born to the mother and father after entry of the decree of divorce may be added to the decree by modification.

(5) (a) In determining parent-time rights of parents and visitation rights of grandparents and other members of the immediate family, the court shall consider the best interest of the child.

(b) Upon a specific finding by the court of the need for peace officer enforcement, the court may include in an order establishing a parent-time or visitation schedule a provision, among other things, authorizing any peace officer to enforce a court-ordered parent-time or visitation schedule entered under this chapter.

(6) If a petition for modification of child custody or parent-time provisions of a court order is made and denied, the court shall order the petitioner to pay the reasonable attorneys' fees expended by the prevailing party in that action, if the court determines that the petition was without merit and not asserted or defended against in good faith.

(7) If a petition alleges noncompliance with a parent-time order by a parent, or a visitation order by a grandparent or other member of the immediate family where a visitation or parent-time right has been previously granted by the court, the court may award to the prevailing party costs, including actual attorney fees and court costs incurred by the prevailing party because of the other party's failure to provide or exercise court-ordered visitation or

parent-time.

(8) (a) The court shall consider at least the following factors in determining alimony:

(i) the financial condition and needs of the recipient spouse;

(ii) the recipient's earning capacity or ability to produce income;

(iii) the ability of the payor spouse to provide support;

(iv) the length of the marriage;

(v) whether the recipient spouse has custody of minor children requiring support;

(vi) whether the recipient spouse worked in a business owned or operated by the payor spouse; and

(vii) whether the recipient spouse directly contributed to any increase in the payor spouse's skill by paying for education received by the payor spouse or allowing the payor spouse to attend school during the marriage.

(b) The court may consider the fault of the parties in determining alimony.

(c) As a general rule, the court should look to the standard of living, existing at the time of separation, in determining alimony in accordance with Subsection (8)(a). However, the court shall consider all relevant facts and equitable principles and may, in its discretion, base alimony on the standard of living that existed at the time of trial. In marriages of short duration, when no children have been conceived or born during the marriage, the court may consider the standard of living that existed at the time of the marriage.

(d) The court may, under appropriate circumstances, attempt to equalize the parties' respective standards of living.

(e) When a marriage of long duration dissolves on the threshold of a major change in the income of one of the spouses due to the collective efforts of both, that change shall be considered in dividing the marital property and in determining the amount of alimony. If one spouse's earning capacity has been greatly enhanced through the efforts of both spouses during the marriage, the court may make a compensating adjustment in dividing the marital property and awarding alimony.

(f) In determining alimony when a marriage of short duration dissolves, and no children have been conceived or born during the marriage, the court may consider restoring each party to the condition which existed at the time of the marriage.

(g) (i) The court has continuing jurisdiction to make substantive changes and new

orders regarding alimony based on a substantial material change in circumstances not foreseeable at the time of the divorce.

(ii) The court may not modify alimony or issue a new order for alimony to address needs of the recipient that did not exist at the time the decree was entered, unless the court finds extenuating circumstances that justify that action.

(iii) In determining alimony, the income of any subsequent spouse of the payor may not be considered, except as provided in this Subsection (8).

(A) The court may consider the subsequent spouse's financial ability to share living expenses.

(B) The court may consider the income of a subsequent spouse if the court finds that the payor's improper conduct justifies that consideration.

(h) Alimony may not be ordered for a duration longer than the number of years that the marriage existed unless, at any time prior to termination of alimony, the court finds extenuating circumstances that justify the payment of alimony for a longer period of time.

(9) Unless a decree of divorce specifically provides otherwise, any order of the court that a party pay alimony to a former spouse automatically terminates upon the remarriage or death of that former spouse. However, if the remarriage is annulled and found to be void ab initio, payment of alimony shall resume if the party paying alimony is made a party to the action of annulment and his rights are determined.

(10) Any order of the court that a party pay alimony to a former spouse terminates upon establishment by the party paying alimony that the former spouse is cohabitating with another person.

Section 2. Section **30-3-5.5** is enacted to read:

30-3-5.5. Designation of Primary and Secondary Health, Dental or Hospital Insurance Coverage.

(1) For purposes of this section, "health, hospital or dental insurance plan" has the same meaning as "health care insurance" as defined in Section 31A-1-301.

(2) (a) A decree of divorce rendered in accordance with Section 30-3-5, an order for medical expenses rendered in accordance with Section 78B-12-212, and an administrative order under Section 62A-11-326 shall, in accordance with Subsection (2)(b)(ii), designate which parent's health, hospital or dental insurance plan is primary coverage and which parent's

health, hospital, or dental insurance plan is secondary coverage for a dependent child.

(b) The provisions of the court order required by Subsection (2)(a):

(i) shall take effect if at any time a dependent child is covered by both parents' health, hospital, or dental insurance plans; and

(ii) shall include the following language:

"If, at any point in time, a dependent child is covered by the health, hospital, or dental insurance plans of both parents, the health, hospital, or dental insurance plan of (Parent's Name) shall be primary coverage for the dependent child and the health, hospital, or dental insurance plan of (Other Parent's Name) shall be secondary coverage for the dependent child. If a parent remarries and his or her dependent child is not covered by that parent's health, hospital, or dental insurance plan but is covered by a step-parent's plan, the health, hospital, or dental insurance plan of the step-parent shall be treated as if it is the plan of the remarried parent and shall retain the same designation as the primary or secondary plan of the dependent child."

(c) A decree of divorce or related court order may not modify the language required by Subsection (2)(b)(ii).

(d) Notwithstanding Subsection (2)(c), a court may allocate the payment of medical expenses including co-payments, deductibles, and co-insurance not covered by health insurance between the parents in accordance with Subsections 30-3-5(1)(a) and 78B-12-212(6).

(2) In designating primary coverage pursuant to Subsection (2), a court may take into account:

(a) the birth dates of the parents;

(b) a requirement in a court order, if any, for one of the parents to maintain health insurance coverage for a dependent child;

(c) the parent with physical custody of the dependent child; or

(d) any other factor the court considers relevant.

Section 3. Section **31A-22-619** is amended to read:

31A-22-619. Coordination of benefits.

(1) The commissioner shall: [~~(a) convene a group of health insurers and health care providers for the purpose of making recommendations to the Legislature regarding an efficient method of coordination of benefits to increase the timeliness and accuracy of coordination of~~

~~benefits;(b) report to the Legislature's Health Reform Task Force before November 15, 2009 regarding legislation to enact the recommendations developed under Subsection (1)(a); and (c)~~]

(a) adopt rules concerning the coordination of benefits between accident and health insurance policies[~~.~~];

(b) publish a coordination of benefits guide;

(c) post the coordination of benefits guide on the state insurance exchange; and

(d) work with the Health Data Authority; health care provider groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims to develop standardized language regarding coordination of benefits for the purpose of including the standardized language in an insurer's explanation of benefits.

(2) Rules adopted by the commissioner under Subsection (1):

(a) may not prohibit coordination of benefits with individual accident and health insurance policies; [~~and~~]

(b) shall apply equally to all accident and health insurance policies without regard to whether the policies are group or individual policies[~~.~~]; and

(c) shall include standardized language regarding the coordination of benefits process that shall be included in each insurer's accident and health insurance policy.

Section 4. Section **62A-11-326** is amended to read:

62A-11-326. Medical and dental expenses of dependent children.

In any action under this part, the office and the department in their orders:

(1) shall include a provision assigning responsibility for cash medical support; and

(2) shall include a provision requiring the purchase and maintenance of appropriate medical, hospital, and dental care insurance for those children, if:

(a) insurance coverage is or becomes available at a reasonable cost; and

(b) the insurance coverage is accessible to the children[~~.~~]; and

(3) shall include a designation of which health, dental or hospital insurance plan is primary and which is secondary in accordance with the provisions of Section 30-3-5.5 which will take effect if at any time the dependent children are covered by both parents' health, hospital or dental insurance plans.

Section 5. Section **63I-2-231** is amended to read:

63I-2-231. Repeal dates, Title 31A.

[~~(1)~~] Section 31A-23a-415 is repealed July 1, 2011.

[~~(2) Section 31A-22-619 is repealed July 1, 2010.~~]

Section 6. Section **78B-12-212** is amended to read:

78B-12-212. Medical expenses.

(1) (a) The court shall order that insurance for the medical expenses of the minor children be provided by a parent if it is available at a reasonable cost.

(b) The court shall, in accordance with Section 30-3-5, designate which health, hospital, or dental insurance plan is primary and which health, hospital, or dental insurance plan is secondary if at any time a dependent child is covered by both parents' health, hospital or dental insurance plans.

(2) In determining which parent shall be ordered to maintain insurance for medical expenses, the court or administrative agency may consider the:

(a) reasonableness of the cost;

(b) availability of a group insurance policy;

(c) coverage of the policy; and

(d) preference of the custodial parent.

(3) The order shall require each parent to share equally the out-of-pocket costs of the premium actually paid by a parent for the children's portion of insurance unless the court finds good cause to order otherwise.

(4) The parent who provides the insurance coverage may receive credit against the base child support award or recover the other parent's share of the children's portion of the premium. In cases in which the parent does not have insurance but another member of the parent's household provides insurance coverage for the children, the parent may receive credit against the base child support award or recover the other parent's share of the children's portion of the premium.

(5) The children's portion of the premium is a per capita share of the premium actually paid. The premium expense for the children shall be calculated by dividing the premium amount by the number of persons covered under the policy and multiplying the result by the number of children in the instant case.

(6) The order shall, in accordance with Subsection 30-3-5 (1)(b), include a cash medical support provision that requires each parent to equally share all reasonable and

necessary uninsured and unreimbursed medical and dental expenses incurred for the dependent children, including but not limited to deductibles and copayments unless the court finds good cause to order otherwise.

(7) The parent ordered to maintain insurance shall provide verification of coverage to the other parent, or to the Office of Recovery Services under Title IV of the Social Security Act, 42 U.S.C. Section 601 et seq., upon initial enrollment of the dependent children, and thereafter on or before January 2 of each calendar year. The parent shall notify the other parent, or the Office of Recovery Services under Title IV of the Social Security Act, 42 U.S.C. Section 601 et seq., of any change of insurance carrier, premium, or benefits within 30 calendar days of the date the parent first knew or should have known of the change.

(8) A parent who incurs medical expenses shall provide written verification of the cost and payment of medical expenses to the other parent within 30 days of payment.

(9) In addition to any other sanctions provided by the court, a parent incurring medical expenses may be denied the right to receive credit for the expenses or to recover the other parent's share of the expenses if that parent fails to comply with Subsections (7) and (8).

Section 7. **Repealer.**

This bill repeals:

Section **31A-22-619.5 (Effective 07/01/10), Coordination of benefits.**

AMENDMENTS TO HEALTH INSURANCE COVERAGE IN STATE CONTRACTS

2010 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends provisions related to the requirement that contractors with certain state entities must provide qualified health insurance to their employees and the dependents of the employees who work or reside in the state.

Highlighted Provisions:

This bill:

- clarifies the application of a waiting period for health insurance may not exceed the first of the month following 90 days of the date of hire;
- clarifies that the qualified health insurance coverage must be offered to employees and dependents who work or reside in the state;
- clarifies that the qualified health insurance coverage that must be offered is a minimum standard and an employer may offer greater coverage;
- amends the definition of qualified health insurance coverage to clarify the standards;
- amends the enforcement provisions to provide protections for good faith compliance; and
- clarifies how an employer offering a defined contribution arrangement may comply with state contract requirements.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as enacted by Laws of Utah 2009, Chapter 13

19-1-206, as enacted by Laws of Utah 2009, Chapter 13

63A-5-205, as last amended by Laws of Utah 2009, Chapter 13

63C-9-403, as enacted by Laws of Utah 2009, Chapter 13

72-6-107.5, as enacted by Laws of Utah 2009, Chapter 13

79-2-404, as enacted by Laws of Utah 2009, Chapter 13

ENACTS:

31A-30-209, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **17B-2a-818.5** is amended to read:

17B-2a-818.5. Contracting powers of public transit districts -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 90 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" means [~~a health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a), in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[;] who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who work or reside in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(c)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) Except as provided in Subsection (3), this section applies to all contracts entered into by the public transit district on or after July 1, 2009, if:

(a) the contract is for design or construction; and

(b) (i) the prime contract is in the amount of $1,500,000 or greater; or

(ii) a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,

or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit district that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employee's dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall demonstrate to the public transit district that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employee's dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with [~~administrative rules~~] an ordinance adopted by the public transit district under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with [~~administrative rules~~] an ordinance adopted by the public transit district under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The public transit district shall adopt [~~administrative rules~~] ordinances:

[~~(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;~~]

[~~(b)~~] (a) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

[~~(vi) the Legislature's Administrative Rules Review Committee; and~~]

[~~(c)~~] (b) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the public transit district compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; [~~and~~]

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract[~~.~~]; and

(iii) a website on which the district shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c)(i).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if a department or division determines that compliance with this section is not required under the provisions of Subsections (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 2. Section **19-1-206** is amended to read:

19-1-206. Contracting powers of department -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 90 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" means [~~a health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a),in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[~~;~~] who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who work or reside in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(c)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) Except as provided in Subsection (3), this section applies to all contracts entered into by or delegated to the department or a division or board of the department on or after July 1, 2009, if:

(a) the contract is for design or construction; and

(b) (i) the prime contract is in the amount of $1,500,000 or greater; or

(ii) a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply to contracts entered into by the department or a division or board of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division or board of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

(c) the executive director determines that applying the requirements of this section to a particular contract interferes with the effective response to an immediate health and safety threat from the environment; or

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6-102, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall demonstrate to the executive director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) a public transit district in accordance with Section 17B-2a-818.5;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the public transit district compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; [~~and~~]

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into

future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract[.]; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c)(i).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if the department determines that compliance with this section is not required under the provisions of Subsections (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or

contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 3. Section **31A-30-209** is enacted to read:

31A-30-209. State contract requirements -- Employer default plans.

(1) This section applies to an employer who is required to offer its employees a health benefit plan as a condition of qualifying for a state contract under:

(a) Section 17B-2a-818.5;

(b) Section 19-1-206;

(c) Subsection 53A-5-205(3);

(d) Section 63C-9-403;

(e) Section 72-6-107.5; and

(f) Section 79-2-404.

(2) An employer described in Subsection (1) shall, when selecting the default plan required in Section 31A-30-204, select a default plan that is "qualified health insurance coverage" as defined in the sections listed in Subsections (1)(a) through (f).

Section 4. Section **63A-5-205** is amended to read:

63A-5-205. Contracting powers of director -- Retainage -- Health insurance coverage.

(1) As used in this section:

(a) "Capital developments" has the same meaning as provided in Section 63A-5-104.

(b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.

(c) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 90 days from the date of hire.

(d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(e) "Qualified health insurance coverage" means [~~a health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate

actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a) in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[~~;~~] who work and reside in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(e)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who work or reside in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(e)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) In accordance with Title 63G, Chapter 6, Utah Procurement Code, the director may:

(a) subject to Subsection (3), enter into contracts for any work or professional services which the division or the State Building Board may do or have done; and

(b) as a condition of any contract for architectural or engineering services, prohibit the architect or engineer from retaining a sales or agent engineer for the necessary design work.

(3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all contracts entered into by the division or the State Building Board on or after July 1, 2009, if:

(i) the contract is for design or construction; and

(ii) (A) the prime contract is in the amount of $1,500,000 or greater; or

(B) a subcontract is in the amount of $750,000 or greater.

(b) This Subsection (3) does not apply:

(i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

(ii) if the contract is a sole source contract;

(iii) if the contract is an emergency procurement; or

(iv) to a change order as defined in Section 63G-6-102, or a modification to a contract, when the contract does not meet the threshold required by Subsection (3)(a).

(c) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

(d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents.

(ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor shall demonstrate to the director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents.

(e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (3)(f).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (3)(d)(ii).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii) during the duration of the contract is subject to penalties in accordance with administrative

rules adopted by the division under Subsection (3)(f).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (3)(d)(i).

(f) The division shall adopt administrative rules:

(i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(ii) in coordination with:

(A) the Department of Environmental Quality in accordance with Section 19-1-206;

(B) the Department of Natural Resources in accordance with Section 79-2-404;

(C) a public transit district in accordance with Section 17B-2a-818.5;

(D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(E) the Department of Transportation in accordance with Section 72-6-107.5; and

(F) the Legislature's Administrative Rules Review Committee; and

(iii) which establish:

(A) the requirements and procedures a contractor must follow to demonstrate to the director compliance with this Subsection (3) which shall include:

(I) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(II) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; [~~and~~]

(B) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this Subsection (3), which may include:

(I) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(II) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(III) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(IV) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an

employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract[~~.~~]; and

(C) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(e)(i).

(g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (g)(i) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if the department determines that compliance with this section is not required under the provisions of Subsection (3)(b).

[~~(ii)~~] (iii) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (3)(g).

(h) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402.

(i) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(i) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(ii) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(4) The judgment of the director as to the responsibility and qualifications of a bidder is conclusive, except in case of fraud or bad faith.

(5) The division shall make all payments to the contractor for completed work in accordance with the contract and pay the interest specified in the contract on any payments that are late.

(6) If any payment on a contract with a private contractor to do work for the division or the State Building Board is retained or withheld, it shall be retained or withheld and released as provided in Section 13-8-5.

Section 5. Section **63C-9-403** is amended to read:

63C-9-403. Contracting power of executive director -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first of the calendar month following 90 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" means [~~a health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a), in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[~~;~~] who work or reside in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible

health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who work or reside in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(c)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) Except as provided in Subsection (3), this section applies to all contracts entered into by the board or on behalf of the board on or after July 1, 2009, if:

(a) the contract is for design or construction; and

(b) (i) the prime contract is in the amount of $1,500,000 or greater; or

(ii) a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6-102, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health insurance

coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall demonstrate to the executive director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) a public transit district in accordance with Section 17B-2a-818.5;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the executive director compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required in Subsection (1) is met by

the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; [~~and~~]

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract[~~:~~]; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c)(i).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if the department determines that compliance with this section is not required under the provisions of Subsections (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 6. Section **72-6-107.5** is amended to read:

72-6-107.5. Construction of improvements of highway -- Contracts -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 90 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" means [~~a health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a), in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[~~;~~] who work or reside in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who reside or work in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(c)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) Except as provided in Subsection (3), this section applies to all contracts entered into by the department on or after July 1, 2009, for construction or design of highways if:

(a) the prime contract is in the amount of $1,500,000 or greater; or

(b) a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6-102, or a modification to a contract, when the contract does not meet the initial threshold required

by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall demonstrate to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) a public transit district in accordance with Section 17B-2a-818.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the

department compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; [~~and~~]

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract[~~.~~]; and

(iii) a website on which th department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c)(i).

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if the department determines that compliance with this section is not required under the provisions of Subsections (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 7. Section **79-2-404** is amended to read:

79-2-404. Contracting powers of department -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 90 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" means a [~~health benefit plan that~~] at the time the contract is entered into or renewed:

(i) [~~(A) provides coverage that is actuarially equivalent to the current benefit plan~~] a health benefit plan and employer contribution level that provides coverage with an aggregate actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance organization that has the largest insured commercial, non-Medicaid, enrollment of covered lives in the state, as determined by the Children's Health Insurance Program under [~~Section 26-40-106; and~~] Subsection 26-40-106(2)(a) in which:

[~~(B) under which~~] (A) the employer pays at least 50% of the premium for the employee and the dependents of the employee[;] who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather than the deductible and out of pocket maximum based on income levels, the deductible is $750 and the out of pocket maximum is $3,000;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:

(I) a deductible that is either:

[~~(I)~~] (Aa) the lowest deductible permitted for a federally qualified high deductible health plan; [~~and~~] or

(Bb) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan; and

(II) an out of pocket maximum that does not exceed three times the amount of the annual deductible; and

(B) under which the employer pays 75% of the premium for the employee and the dependents of the employee[~~; or~~] who work or reside in the state.

[~~(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan determined under Subsection (1)(c)(i); and~~]

[~~(B) under which the employer pays at least 75% of the premium of the employee and the dependents of the employee.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) Except as provided in Subsection (3), this section applies to all contracts entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if:

(a) the contract is for design or construction; and

(b) (i) the prime contract is in the amount of $1,500,000 or greater; or

(ii) a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply to contracts entered into by the department or a

division, board, or council of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division, board, or council of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6-102, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor shall demonstrate to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) a public transit district in accordance with Section 17B-2a-818.5;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate compliance with this section to the department which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer; and

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; [~~and~~]

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract[~~.~~]; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c)(i).

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs [~~not covered by insurance.~~] that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a) if the employer:

(A) relied in good faith on a written statement of actuarial equivalency provided by an actuary; or

(B) if the department determines that compliance with this section is not required under the provisions of Subsections (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

HEALTH REFORM - UNIFORM ELECTRONIC STANDARDS - INSURANCE INFORMATION

2010 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends provisions related to the use of uniform electronic standards for health insurance claims processing, insurance eligibility, and coordination of benefits.

Highlighted Provisions:

This bill:

- amends provisions related to uniform electronic standards for health insurance claims processing, electronic insurance eligibility information, and electronic information regarding the coordination of benefits;
- establishes a voluntary registry of software vendors who comply with electronic standards; and
- makes clarifying and technical amendments.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill takes effect on July 1, 2010.

Utah Code Sections Affected:

AMENDS:

31A-22-614.5, as last amended by Laws of Utah 2008, Chapters 379 and 382

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-614.5** is amended to read:

31A-22-614.5. Uniform claims processing -- Electronic exchange of health information.

(1) [~~Beginning July 1, 1993, all~~] All insurers offering health insurance shall:

(a) use a uniform claim form and uniform billing and claim codes; and

(b) provide for the electronic exchange of uniform insurance eligibility and coverage information and coordination of benefits information.

(2) (a) The uniform [~~claim forms and billing codes~~] electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. [~~The~~]

(b) When adopting rules under this section the commissioner:

(i) shall consult with [~~the director of the Division of Health Care Financing, the National Uniform Claim Form Task Force, and the National Uniform Billing Committee when adopting the uniform claims and billing codes.~~] national and state organizations involved with the electronic exchange of health data to develop the standards for the use and electronic exchange of uniform claim forms, billing and claim codes, insurance eligibility and coverage information, and coordination of benefits information;

(ii) may not require an insurer or administrator to use a specific software product or vendor; and

(iii) may require an insurer who participates in the All Payer Database created under Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure Health Information Master Person Index to be used:

(A) in compliance with data security standards established by:

(I) federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 standards; and

(II) the electronic commerce agreements established in a business associate agreement; and

(B) for the purpose of coordination of accident and health insurance benefits.

(3) (a) (i) [~~Beginning July 1, 1995, all insurers shall offer compatible systems of~~] In order to facilitate the provision of Subsection (1), an insurer shall use the electronic standards for electronic billing and electronic transmission of eligibility and coverage information approved by the commissioner in accordance with [~~Title 63G, Chapter 3, Utah Administrative Rulemaking Act~~] Subsection (2).

(ii) The [~~systems~~] standards approved by the commissioner may include monitoring and disseminating information concerning eligibility and coverage of individuals.

(iii) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health for the implementation of the standards for the electronic exchange of clinical health information under Section 26-1-37. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health is given the opportunity to comment on proposed rules.

(b) (i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.

(ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:

(A) a not for profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or

(B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).

[~~(b)~~] (c) The commissioner shall regulate any fees charged by insurers to the providers for:

(i) uniform claim forms;

(ii) electronic billing; or

(iii) the electronic exchange of clinical health information permitted by Section 26-1-37.

Section 2. **Effective date.**

This bill takes effect on July 1, 2010.